Public Education Employees' Health Insurance Plan

OPEN ENROLLMENT PACKET 2011-2012

Deadline August 31, 2011

Effective October 1, 2011

The Retirement Systems of Alabama

Public Education Employees' Health Insurance Plan (PEEHIP)

Office Location
201 South Union Street
Montgomery, AL 36104-0001
www.rsa-al.gov

Mailing Address
P. O. Box 302150
Montgomery, AL 36130-2150

Phone Numbers
877.517.0020 or 334.517.7000
Fax: 877.517.0021 or 334.517.7001

Flexible Spending Accounts
877.517.0020 or 334.517.7000
www.rsa-al.gov/peehip/flex.html

Wellness Program, Weight Watchers, & ALL Kids (Administered by the Department of Public Health)

RSA Tower, Suite 900
P.O. Box 303170
Montgomery, AL 36130-3017
www.adph.org

Tobacco Cessation Quitline
800.QUIT.NOW
800.784.8669

Phone Numbers
334.206.5300 or 800.252.1818

ALL Kids
P.O. Box 304839
Montgomery, AL 36130-4839
888.373.5437
www.adph.org/allkids

Blue Cross Blue Shield of Alabama - Administrator of Hospital/Medical, Flexible Spending Accounts, & Supplemental Plans

450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298
www.bcbsal.org/peehip1/

Customer Service
800.327.3994

Preadmission Certification
800.248.2342

Flexible Benefits
800.213.7930
www.bcbsal.org/peehip1/

Rapid Response to order ID cards, directories & claim forms
800.248.5123

Baby Yourself
800.222.4379

Fraud Hot Line
800.824.4391

MedImpact - Administrator of Core Pharmacy

10680 Treena St
San Diego, CA 92131
https://mp.medimpact.com/ala

Customer Service
(Available 24 hours/day)
877.606.0727

Pharmacy Help Desk
(Available 24 hours/day)
800.788.2949

Step Therapy Prior Authorization
(For Physician Use)
800.347.5841
Fax: 877.606.0728

Bioscrip Specialty Pharmacy - Administrator of Specialty Pharmacy

2791 Charter St
Columbus, OH 43228
www.bioscrippeehip.com

Customer Service
877.694.5320
Fax: 877.212.8388 *(For Physician Use)*

VIVA Health Plan

1222 14th Avenue South
Birmingham, AL 35205
www.vivahealth.com/PEEHIP

205.558.7474
800.294.7780

Delta Dental Customer Service
(Dental provider for Viva Health Plan)
800.521.2651

Southland Benefit Solutions - Administrator of Cancer, Dental, Indemnity, & Vision Optional Plans

1812 University Blvd.
P.O. Box 1250
Tuscaloosa, AL 35403

800.476.0677
www.southlandnationalpeehip.com

Open Enrollment Information

The Public Education Employees' Health Insurance Plan (PEEHIP) welcomes you to this year's Open Enrollment Packet. This packet is an important part of our commitment to provide PEEHIP members with valuable information about their health care benefits. This packet is designed to make it easy for you to find all the information you need to make an informed decision about your health plan selections. Please read this packet carefully and keep it with your other PEEHIP and retirement materials. We encourage you to review your PEEHIP coverage(s) and choose the plans that are right for you.

This is your once-a-year opportunity to enroll, make changes, or terminate coverage during the 2011 Open Enrollment period. Open Enrollment begins July 1, 2011, and will end by the following deadlines:

- The deadline for submitting **paper** Open Enrollment forms is **August 31, 2011**. Any paper forms postmarked after August 31, 2011, will not be accepted.
- The deadline for submitting **online** Open Enrollment changes is midnight of **September 10, 2011**. After September 10, 2011, online Open Enrollment changes will not be accepted and the Open Enrollment link will be closed.
- The deadline for enrollment or re-enrolling in a **Flexible Spending Account** online or on paper is **September 30, 2011**.
- No changes in address, coverage, or tobacco status can be made by phone.

Effective Date of Coverage: All Open Enrollment elections approved by PEEHIP will have an effective date of October 1, 2011.

Open Enrollment web page: PEEHIP created an Open Enrollment web page designed to make it easy for you to find all the information you need to make an informed decision about your health plan selections. You will find FAQs, tutorials, deadlines, Open Enrollment Packets and other pertinent information about Open Enrollment. Go to www.rsa-al.gov/PEEHIP/open-enroll.html to learn more.

Open Enrollment Packets: The 2011-2012 packets are available on the PEEHIP Open Enrollment web page July 1, 2011. **IMPORTANT:** Just as last year, PEEHIP will **not** be mailing a 2011-2012 Open Enrollment packet to its members. Instead, active and retired members can view and/or download a copy of the Open Enrollment packet from the PEEHIP Open Enrollment web page at www.rsa-al.gov/PEEHIP/open-enroll.html. Members can make their insurance changes through Member Online Services at www.rsa-al.gov as well beginning July 1, 2011. For those members who do not have internet access and cannot download the information, an Open Enrollment packet can be mailed upon request. Please contact RSA Member Services at 877.517.0020 to request an Open Enrollment packet.

This year, make your Open Enrollment changes online! Say good-bye to paperwork as PEEHIP's Member Online Services offers a simple, convenient way to enroll for and make changes to your benefits electronically. **Approximately 60% of all Open Enrollments submitted last year were made online, and we anticipate and encourage a greater percentage of online enrollments this year!** The online system is fast, free, secure and accurate! The online system operates in real-time so by the time you receive your Confirmation page, your Open Enrollment elections are already processed and in our system. Your Confirmation page confirms the date and time that your elections were saved and submitted to PEEHIP; gives a recap of your elections; displays your actual PEEHIP coverages; and provides your premium calculation so that you will know what your monthly out-of-pocket premium will be! **We encourage you to use the online system to make your Open Enrollment changes this year!**

Helpful information about Open Enrollment:

- If you wish to continue the current insurance coverage you are enrolled in and do **not** want to make changes to your PEEHIP Hospital Medical or Optional Coverage plans, **you do not need to complete new forms**. You will automatically remain enrolled in your present insurance coverage.
- **Exception:** Eligible members must re-enroll each year to renew the **Flexible Spending Accounts and Federal Poverty Level Premium (FPL) discount** program as these programs do not automatically renew each year without a new application. To re-enroll in the Flex plan, you can use the form in the back of this handbook or use the Member Online System at www.rsa-al.gov. Retired members are not eligible to enroll in the Flexible Spending plans. To re-enroll in the FPL program and receive a discount on your Hospital Medical premium, you must complete the appropriate application in the back of this packet.
- Members enrolling in new insurance plans should receive their new ID cards no later than the last week in September.
- The new payroll deduction for changes made to your PEEHIP insurance coverage during Open Enrollment will be reflected in your September paycheck.
- All members covered by PEEHIP insurance should review their paycheck stub each month to ensure the proper amount has been deducted for their PEEHIP premiums.

- Active members electing to enroll in the Flexible Spending Accounts will have their first Flex contribution amount deducted from their October paycheck.
- All of the Open Enrollment forms are in the back of this packet and a self-addressed envelope is provided for your convenience.
- You are not required to certify your Tobacco Certification every year unless you or your spouse have a change in your tobacco usage status. You can certify changes in tobacco usage status to PEEHIP by completing the tobacco usage questions on the Health Insurance and Optional Status Change form and mailing the form to PEEHIP.
- Waiting periods for pre-existing conditions will be waived for all new coverages effective October 1, 2011.

New PEEHIP Policies, Benefit and Premium Changes Effective October 1, 2011

Premium Rate Changes

- The PEEHIP Board met in May and voted to make only minimal changes in the premium rates for fiscal year 2012, despite a 5.05% reduction in PEEHIP's funding by the Legislature for the upcoming 2012 fiscal year. Changes to the premiums, benefits, and policies implemented last fiscal year to address the funding crisis and provide reasonable assurance of the stability and sustainability of the plan in future years is a contributing factor in the Board's ability to keep the out-of-pocket rate increases at a very minimal amount.
- The Hospital Medical premium rates for active employee single and family coverage and the Medicare-eligible retiree single and family coverage will remain the same as last years' rates. The COBRA, Leave of Absence and Surviving Spouse premium rates will all decrease.
- Active and retired employees are eligible for a premium discount if their income falls within 300% of he Federal Poverty Level. The Federal Poverty Level Assistance Application (FPL) and income charts are shown on the last page of this booklet.

Common Law Spouses No Longer Covered

- Pursuant to Board action **effective May 6, 2011**, PEEHIP will no longer approve new common-law spouses as eligible dependents. However, members who currently have a common-law spouse on their PEEHIP coverage will be allowed to produce a valid marriage certificate to remain an eligible dependent no later than **October 1, 2011**. Failure to produce a valid marriage certificate by October 1, 2011, will result in a cancellation of coverage for the common law spouse. The cancelled spouse may enroll in COBRA coverage for up to a period of 36 months if a timely request is made to PEEHIP by the member or spouse.
- PEEHIP provides eligibility for a spouse to whom a member is currently and legally married and requires a copy of a marriage certificate to verify eligibility and one additional current document to show proof of current marital status such as one of the following:
  - ◊ Page 1 and signature page of member's 2010 Federal Income Tax Return (1040, 1040A or 1040EZ) as filed with the IRS listing the spouse
  - ◊ Current mortgage statement, home equity loan, or lease agreement listing both member and spouse
  - ◊ Current property tax documents listing both member and spouse
  - ◊ Automobile registration that is currently in effect listing both member and spouse
  - ◊ Current credit card or account statement listing both member and spouse
  - ◊ Current utility bill listing both member and spouse
  - ◊ Current utility bill listing the spouse at the same address as the member

Note: *"Current" is defined as within the last six months.*

VIVA Health Plan Benefit Changes

- Outpatient Hospital copayment - $100
- Emergency Room copayment - $100
- Prescription Drug copayments - $30 for preferred drugs, $50 for non-preferred drugs; the generic drug copayment remains $12

Combining of Allocation Program - 3-Year Phase-Out

- The Combining of Allocation program terminated on October 1, 2010. Elimination of this program now requires that if a couple has each other covered on their family PEEHIP Hospital Medical Plan, they must use both allocations towards the family Hospital Medical Plan and cannot use one of the allocations towards the Optional Plans. All current

participating members were grandfathered in and experienced premium rate increases that were to be phased in over a 3-year period. The rates are explained in more detail on page 6.

- In many cases, a **husband and wife with no other dependents** may find that it is more cost efficient to uncombine during the Open Enrollment period and change to two single policies.
- However, if the couple has each other and additional dependents covered on their family plan, they must use both allocations for the family Hospital Medical Plan and cannot use one of the allocations towards the Optional Plans. The family hospital medical premium will be a reduced rate until October 1, 2012. Couples can still purchase the Optional Plans at the normal monthly rate of $38 or $45 for family dental.
- If one member is enrolled in the family Hospital Medical Supplemental Plan (premium $0), the spouse can use his or her allocation and receive the Optional Plans at no cost.
- You have the opportunity to make changes to your insurance plan during the current Open Enrollment period which starts July 1 and ends August 31 for paper forms, or on midnight of September 10 if you use the PEEHIP online system.
- If you decide to uncombine allocations, **the easiest, most efficient and preferred way to uncombine allocations and enroll in single hospital medical plans is online through Member Online Services (MOS).** The subscriber of the hospital medical policy (for example, the receiver of the allocation) must first change **from** family hospital medical coverage **to** single hospital medical coverage. Once you receive a confirmation page generated by MOS confirming this election, the sender of the allocation should then log in to MOS and enroll in single hospital medical coverage and receive a confirmation page confirming this election. **Your confirmation page will also provide your premium calculation.** Each member must use his/her own PID number when using the MOS system.

Prescription Drug Changes

The PEEHIP Board approved some changes to the drugs that require a prior authorization, minor changes in the Step Therapy program, and Quantity Level Limits. Any members affected by these changes will be sent a letter from PEEHIP. Also, Nexium will be moved to the third tier and will cost $60 per prescription beginning October 1, 2011. Therapeutically equivalent drugs such as lansoprazole, omeprazole, and pantoprazole can be purchased instead of Nexium for $6 per prescription. More detailed information about the prescription drug changes can be found in the June edition of the *PEEHIP Advisor*.

The Wellness and Weight Watchers Program

The Wellness and Weight Watchers program will continue to allow active and retired members and covered dependents to once again participate in free health screenings provided by the Public Health Department nurses. PEEHIP offers the Weight Watchers program to allow eligible members to participate in a 15-week Weight Watchers program for only $85. Members who have a body mass index of 25 or more will be eligible to participate in the PEEHIP Weight Watchers program. You must attend at least 12 out of the 15 sessions to get reimbursement. Additional information can be obtained on the Public Health Department website at **www.adph.org/worksitewellness** or by calling 800.252.1818 and asking for the Wellness Division. The wellness screenings are intended to assist employees and their families identify health risks and receive early and necessary treatment and ultimately lower health care costs.

Adult Children

PEEHIP will continue to offer and extend dependent hospital medical coverage (at the member's option) to adult children up to age 26. Members are allowed to enroll their adult child(ren) during the annual Open Enrollment period which begins July 1 and ends August 31 for an October 1 effective date. Maternity benefits are not covered for children of any age regardless of marital status.

In accordance with the Federal Health Care Reform Legislation, the following adult children are eligible for coverage under any of the PEEHIP plans.

1. A married or unmarried child if the child is your biological child, adopted child, foster child, or stepchild without conditions of residency, student status or dependency. A foster child is any child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
2. The eligibility requirements for any other children such as grandchildren must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody, legal guardianship. **However, PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage.** Also, maternity benefits are not covered for children of any age regardless of marital status.
3. The eligibility requirements for permanently incapacitated dependents age 26 and over remain the same.

Documents Required by PEEHIP

Every member who has a dependent enrolled on his or her PEEHIP coverage(s) is required to certify to PEEHIP their dependent's eligibility. Certification will require appropriate documents to support your dependent's eligibility. Required documents are a marriage certificate and one additional document to show proof of current marital status for a spouse; a birth certificate for a natural child; a certificate of adoption for an adopted child; a marriage certificate and a birth certificate for a step child; a placement authorization for a foster child; a court order signed by a judge appointing legal guardianship or legal custody for other children who are not biological, adopted or step children. Enrollments cannot be processed without the appropriate documentation as explained above. PEEHIP is not bound by a court order to ensure dependents who do not meet PEEHIP guidelines.

Flexible Spending Accounts

The PEEHIP Flexible Spending Accounts program is available to all active members of PEEHIP and is a great way to offset the costs of your out-of-pocket copayments and deductibles. Retired members are not eligible to participate in any of the Flexible Spending Accounts.

Here is how a Flexible Spending Account works - easy as 1, 2, 3:

1. You contribute pre-tax dollars into your Flexible Spending Account via payroll deduction.
2. You submit eligible expenses for reimbursement throughout the year.
3. The money you paid out-of-pocket is reimbursed to you from your Flexible Spending Account.

The Open Enrollment deadline for the Flexible Spending Accounts is September 30, 2011, for an effective date of October 1, 2011. Members who are currently enrolled in a Flexible Spending Account through their employer are allowed to enroll in the PEEHIP spending accounts at the end of their employer's plan year. To continue the Flex Plan, members currently enrolled in the PEEHIP Flexible Spending Accounts must re-enroll every year. These programs do not automatically renew each year.

Additional information about the PEEHIP Flexible Spending Accounts program can be found on page 18 of this packet and on the PEEHIP Flex Web site at **www.rsa-al.gov/peehip/flex.html**.

Don't let a valuable opportunity pass you by - enroll in a PEEHIP Flexible Spending Account (FSA) before the deadline of September 30, 2011! An FSA allows you to set aside pre-tax money via payroll deductions in a Health and/or a Dependent Care account. An FSA provides you with a tax break on eligible health care and dependent care expenses. Remember to enroll or re-enroll by the deadline!

Baby Yourself Program

Blue Cross and Blue Shield of Alabama and PEEHIP offer Baby Yourself, a prenatal wellness program for expectant mothers. This program is part of your PEEHIP Hospital Medical coverage and is available at no cost to you. PEEHIP strongly encourages all expectant mothers covered under the PEEHIP Hospital Medical plan to sign up for Baby Yourself today. It is never too late to sign up during your pregnancy, but the sooner you sign up the better. If you are a soon-to-be expectant mother, please sign up as soon as you confirm your pregnancy. PEEHIP encourages you to sign up for the program with each pregnancy even if you have already participated. When you sign up, you will receive:

- Support from an experienced Blue Cross registered nurse
- Educational information by telephone and email during your pregnancy
- Useful gifts that encourage healthy habits, proper prenatal care, and help you understand the changes and challenges of pregnancy

The vast majority of mothers who delivered premature babies did not participate in the PEEHIP Baby Yourself program. The goal of Baby Yourself is to have healthy mothers and babies at delivery. If you are pregnant, please enroll today in Baby Yourself by calling 800.222.4379 or register online at **www.behealthy.com**.

Premium Rates 2011 - 2012 Plan Year

The following monthly premiums are effective October 1, 2011 - September 30, 2012. **These rates do not include the $28 monthly tobacco premium.**

Full-time Active Members

PEEHIP Hospital Medical or HMO Plan

Coverage		Allocation - Cost to State	Monthly Out-of-Pocket Cost
Single	$729	$714	$ 15
Family	$891	$714	$177

PEEHIP Supplemental Medical Plan

Single or Family	$0

COBRA and Leave of Absence Rates for the Hospital Medical or HMO Plan

Single	$401
Family	$960

COBRA and Leave of Absence Rates for the Supplemental Medical Plan

Single or Family	$159

Tobacco Premium

Active and Retired Members Member or Spouse	$28

Tobacco Premium applies to the Hospital Medical and HMO plans only.

Retired Members

The premiums listed in the charts below show a retiree's out-of-pocket cost after subtracting the retiree allocation. These rates apply only to members who retired prior to October 1, 2005, or members who retired on or after October 1, 2005, and before January 1, 2012, with 25 years of service. All members who retired on or after October 1, 2005, are subject to the Retiree Sliding Scale premium based on years of service. These retirees will experience a rate adjustment effective October 1, 2011. The sliding scale premium rates can be found on the PEEHIP Web site at www.rsa-al.gov. Click on Premiums and then Retiree Sliding Scale Premium Rates.

Type of Contract	*Retiree Monthly Out-of-Pocket Premium	Cost to State on Behalf of the Retiree
Individual Coverage/ Non-Medicare Eligible Retired Member	$151	$507
Family Coverage/Non-Medicare Eligible Retired Member and Non-Medicare Eligible Dependent(s)	$391	$815
Family Coverage/Non-Medicare Eligible Retired Member and Dependent Medicare Eligible	$250	$747
Individual Coverage/ Medicare Eligible Retired Member	$ 10	$318
Family Coverage/Medicare Eligible Retired Member and Non-Medicare Eligible Dependent(s)	$250	$626
Family Coverage/Medicare Eligible Retired Member and Dependent Medicare Eligible	$109	$558

**This rate applies to the PEEHIP Hospital Medical or the VIVA Health Plan and is the monthly amount that will be deducted from a retiree's check. The VIVA Health Plan is not available to retired members or dependents who are Medicare eligible.*

Combining Allocation Rates

In 2010, the PEEHIP Board voted to eliminate the combining allocation program. All current participating members were grandfathered in and experienced premium rate increases that were to be phased in over a 3-year period. No married couples were able to begin combining allocations effective October 1, 2010. See rate charts below. (*The rates in year 3 below assume no further rate increases. If rates change, the premium amounts shown in year 3 below will change.)

Examples:

- In many cases, a **husband and wife with no other dependents** may find that it is more cost efficient to uncombine during the Open Enrollment period and change to two single policies.
- However, if the couple has each other and additional dependents covered on their family plan, they must use both allocations for the family Hospital Medical Plan and cannot use one of the allocations towards the Optional Plans. The family hospital medical premium will be a reduced rate until October 1, 2012. Couples can still purchase the Optional Plans at the normal monthly rate of $38 or $45 for family dental.
- If one member is enrolled in the family Hospital Medical Supplemental Plan (premium $0), the spouse can use his or her allocation and receive the Optional Plans at no cost.
- If you decide to uncombine allocations, **the easiest, most efficient and preferred way to uncombine allocations and enroll in single hospital medical plans is online through Member Online Services (MOS).** The subscriber of the hospital medical policy (for example, the receiver of the allocation) must first change **from** family hospital medical coverage **to** single hospital medical coverage. Once you receive a confirmation page generated by MOS confirming this election, the sender of the allocation should then log in to MOS and enroll in single hospital medical coverage and receive a confirmation page confirming this election. **Your confirmation page will also provide your premium calculation.** Each member must use his/her own PID number when using the MOS system.

Combining of Allocation Program Phase-Out

Active Members Combining Allocations and Active & Retired Members (under & over 65) Combining Allocations	**New Premium Rates**
- Year 2: Oct 1, 2011 – Sept 30, 2012	$ 118
- Year 3: Oct 1, 2012 – Sept 30, 2013	*$ 177
Retired Members Combining Allocations not subject to sliding scale (based on 25 years of service)	
Year 2: Oct 1, 2011 – Sept 30, 2012	
- Retiree & Dependent NME	$316
- Retiree NME & Dependent ME	$190
- Retiree ME & Dependent NME	$190
- Retiree & Dependent Both ME	$ 73
*Year 3: Oct 1, 2012 – Sept 30, 2013	
- Retiree & Dependent NME	$391
- Retiree NME & Dependent ME	$250
- Retiree ME & Dependent NME	$250
- Retiree & Dependent Both ME	$109

Note: Members who retired on or after October 1, 2005, are subject to the sliding scale premiums which are based on years of service and the cost of the insurance program. A chart illustrating the new sliding scale premiums is posted on the PEEHIP Web site.

Surviving Dependent Monthly Premiums for the 2011-2012 Plan Year

Type of Contract	Monthly Premium for PEEHIP Hospital Medical or the VIVA Health Plan
Individual Coverage/Non-Medicare Eligible (NME) Survivor	$658
Family Coverage/NME Survivor and NME Dependents	$847
Family Coverage/NME Survivor and Only Dependent Medicare Eligible (ME)	$816
Individual Coverage/ME Survivor	$328
Family Coverage/ME Survivor and NME Dependent(s)	$517
Family Coverage/Medicare-eligible Survivor and Only Dependent Medicare-eligible	$486
Optional (Each) - Cancer, Indemnity, Vision, and Single Dental	$ 38
Family Dental Premium	$ 45

Active or retired members who are not enrolled in the Hospital Medical or HMO Plan and are not combining allocations with their spouse can use their state allocation for the Optional Plans or the PEEHIP Supplemental Medical Plan. Full-time active employees will continue to receive all four Optionals at no cost and retirees will continue to receive two Optionals at no cost. If active or retired members choose to use their state allocation for the PEEHIP Supplemental Medical Plan in lieu of the Optional or PEEHIP Hospital Medical Plan, the active or retired allocation will continue to cover the full cost of the PEEHIP Supplemental Medical Plan.

Optional Coverage:	**Active and Retired Members**	
Cancer	$38/month	Individual or Family Coverage
Dental	$38/month	Individual Coverage
	$45/month	Family Coverage
Indemnity	$38/month	Individual or Family Coverage
Vision	$38/month	Individual or Family Coverage

If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office **must receive** a copy of the Medicare card before the premiums can be reduced. However, PEEHIP will pay secondary to Medicare once our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare eligible members and dependents should have Medicare Part A **and** Part B to have adequate coverage with PEEHIP.

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer on the active PEEHIP member. Therefore, the active Medicare-eligible member will need Medicare Part A and Part B coverage.

If the active member who is insured as a dependent on a retired contract does not want Medicare as his primary payer and does not want to enroll in Medicare Part B until retirement, the active member has the option of enrolling in a separate PEEHIP contract as an active member. However, when the active Medicare-eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B must be the date of retirement to avoid a lapse in coverage.

Member Online Services – It's Fast, FREE, Secure and Accurate!

PEEHIP's Member Online Services offers a simple, convenient way to enroll in and make changes to your benefits electronically. **Approximately 60% of all Open Enrollments submitted last year were made online. We anticipate and encourage an even higher percentage of online enrollments this year!** The online system is fast, free, secure and accurate and operates in real-time. By the time you receive your Confirmation page, your Open Enrollment elections are already processed and in our system. Your Confirmation page confirms the date and time that your elections were saved and submitted to PEEHIP; gives a recap of your elections; displays your actual PEEHIP coverages; and provides your premium calculation so that you will know what your monthly out-of-pocket premium will be! **We encourage you to use the online system to make your Open Enrollment changes this year!**

The Open Enrollment link to enroll online will be available beginning July 1, 2011, and remain available through the **entire** Open Enrollment period ending September 10, 2011. To make your Open Enrollment elections online:

1. Go to **www.rsa-al.gov** and click Member Online Services.
2. Enter your User ID and Password at the Log In page.
3. If you do not have a User ID and Password, click "Register Now" and follow the on screen prompts to create your own User ID and Password.
4. Once you successfully log in, click the link "Enroll or Change PEEHIP Coverages" from the PEEHIP menu found at the left of your screen.
5. Click the open enrollment option and then click Continue and follow the on-screen prompts until you receive your Confirmation page.

No more paper forms, envelopes, stamps or last minute runs to the post office when you use the RSA's Member Online Services system! RSA and PEEHIP continually strive to improve the services we provide to our members. Use the electronic Member Online Services system and we all benefit in terms of greater efficiency and effectiveness as well as savings in time and costs!

PEEHIP Members Can Do the Following Online:

- **Year Round:**
  - View your Current Coverages
  - View and/or Update your Contact Information (address, phone number, email and marital status)
  - View the history of your Confirmation pages.
- **During Open Enrollment (for an October 1 effective date):**
  - Enroll, Change or Cancel your Hospital Medical Plan
  - Enroll, Change or Cancel your Optional Coverage Plans (cancer, dental, indemnity and vision)
  - Add, Update or Cancel your Other (non-PEEHIP) Group Insurance Coverage Information
  - Enroll or Re-enroll in Flexible Spending Accounts
  - Add or Update your Medicare Information
  - Add or Update Retiree Employer Information
  - Update your and your Spouse's Tobacco Usage Status
  - Add Dependent(s) to Coverage such as a newborn child or new spouse
  - Cancel Dependent(s) from Coverage
  - Enroll your 19-26 year-old, adult child(ren) to any PEEHIP plan or the VIVA Health Plan
- **Outside of Open Enrollment** - Coverage for new dependents can be added through the online system for the following four **Qualifying Life Events (QLE) (for an effective date of the date of the event or the 1st of the month following the date of the event):**
  - Adoption of a Child
  - Birth of a Child
  - Legal Custody of a Child
  - Marriage of a Subscriber
- **To Uncombine Allocations During Open Enrollment:**
  - **The easiest, most efficient and preferred way to uncombine allocations and enroll in single hospital medical plans is online through Member Online Services (MOS).** The subscriber of the hospital medical policy (for example, the receiver of the allocation) must first change **from** family hospital medical coverage **to** single hospital medical coverage. Once you receive a confirmation page generated by MOS confirming this election, the sender of the allocation should then log in to MOS and enroll in single hospital medical coverage and receive a confirmation page confirming this election. **Your confirmation page will also provide your premium calculation.** Each member must use his/her own PID number when using the MOS system.

- **To Remove An Ex-Spouse From Coverage Effective the 1st Day of the Month Following the Divorce:**
  - Click the "View/Change Contact Information" link once you have logged in to Member Online Services. Select the "Update my marital status" option, select "divorce" from the drop box, and then provide the date the divorce was final. This is the date the judge signed the Final Order of the Divorce Decree. Be sure to get a Confirmation page to ensure this change was saved and submitted to PEEHIP. This will remove the ex-spouse from your coverage.
  - If you do not have access to a computer, you may notify PEEHIP of your divorce by completing and mailing or faxing a paper Health Insurance Status Change form to PEEHIP.

PEEHIP HOSPITAL MEDICAL COVERAGE *(Administered by Blue Cross)*

(Coverage for Active Members and Non-Medicare Eligible Retirees)

Hospital Benefits *(Administered by Blue Cross)*

- Inpatient Hospitalization: Services are covered in full for 365 days without a dollar limit.
- Deductible: $200 for each admission. You are also responsible for the difference between private and semi-private accommodations and other non-medical items, such as TV, phone, etc. There will be an additional copay of $25 for days 2-5.
- Preadmission Certification (PAC): All admissions will be subject to Preadmission Certification by completing a Blue Cross Blue Shield of Alabama Preadmission Certification form. Emergency admissions must be certified by the first business day following the admission by calling 800.354.7412.
- Inpatient Rehabilitation: Coverage in a rehabilitation facility limited to one admission per illness or accident; one per lifetime with a 60-day maximum. Precertification is required.
- Outpatient Hospital Charges: $150 facility copay for outpatient surgery and $150 facility copay for medical emergencies and hemodialysis. There is no copay required for accident related services rendered within 72 hours after the accident.
- Non-medical emergencies will be paid under major medical at 80% of the allowable charge after a $300 calendar year deductible.

Major Medical Benefits *(Administered by Blue Cross)*

- Deductible: $300 deductible per person per calendar year; maximum of 3 deductibles per family per year or $900.
- Coinsurance: After you pay the $300 deductible, the plan pays 80% of the Usual Customary Rates (UCR) of covered expenses for the first $2,000 and 100% UCR thereafter.
- Covered Services: Physician services for medical and surgical care when you do not use a PMD physician; laboratory and X-rays, (outpatient MRI's must be precertified); ambulance service; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; podiatrist services; physical therapy; allergy testing and treatments; semi-private room and other hospital care after basic hospital benefits expire.

Preferred Medical Doctor (PMD)

- $5 Copay Per Test: Outpatient diagnostic lab and pathology (including pap smears).
- $30 Copay Per Visit: Doctor's office visits and consultations; one routine preventive visit each year for adults age 19 and over.

PPO Blue Card Benefits *(Out-of-State Providers)*

- The Blue Card PPO program offers "PMD-like" benefits when members access out-of-state providers if the physician or hospital is a participant in the local Blue Cross PPO program in that state. This program allows members to receive PMD benefits such as well baby care, routine physicals and routine mammograms when accessing out-of-state PPO providers.

Non-Participating Hospitals and Outpatient Facilities

- Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are a Blue Cross and Blue Shield participating provider. With your health plan benefits, you have the freedom to choose your health care provider.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don't have to worry about extra out-of-pocket expenses.

Out-of-Country Coverage

- If you receive medical treatment outside of the United States and the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross of Alabama.

Pharmacy Program *(Administered by MedImpact)*

- Participating Pharmacy: When you choose a Participating Pharmacy you pay the following:
  - $6 for any covered generic prescription drug
  - $40 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Web site at **www.rsa-al.gov**.)
  - $60 for any covered non-preferred brand drug
  - Approved maintenance drugs may be purchased up to a 90-day supply for one copayment of $12 for generic, $80 for preferred and $120 for non-preferred. The drug must be on the approved maintenance list and must be prescribed as a maintenance drug. First fill for a maintenance drug will be a 30-day supply.
- Participating pharmacies will file all claims for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP MedImpact prescription drug plan.
- Members and covered dependents need to use Bioscrip for all specialty medications.
- The PEEHIP prescription drug plan includes Step Therapy, prior authorization, and quantity level limitations for certain medications.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama.
- Coverage outside Alabama: You will file the claim and be reimbursed at the Participating Pharmacy rate less the appropriate copay.

Additional changes

In accordance with the Federal Health Care Reform Legislation, the following two changes have been made to the PEEHIP Hospital Medical Plan benefits:

- PEEHIP will not impose a copayment or deductible expense for immunizations or preventive care.
- PEEHIP will cover emergency services without the need for pre-authorization and will treat out-of-network ER benefits the same as in-network ER benefits.

Excluded Services

- Coverage is not provided for nursing home costs, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids and experimental procedures.

Wellness and Weight Watchers Program

(Administered by the Alabama Department of Public Health)

Members and dependents covered by the PEEHIP Hospital Medical Plan, HMO or Optional Plans can receive free health screening by the Public Health Department nurses at different sites during the year. The health screening tests include blood pressure, glucose, and an HDL/LDL cholesterol screening as well as osteoporosis screenings for high risk members.

The PEEHIP Wellness program also includes a smoking cessation toll-free Quitline (800.784.8669) which is available 24 hours a day providing live counseling from 8:00 a.m. until 8:00 p.m., Monday through Friday. The Wellness program also includes a Weight Watchers benefit for high risk members who have a body mass index of 25 or more. The member's cost is $85 for a 15-week program with PEEHIP paying the remaining $85. Members must attend at least 12 of the 15 sessions to receive full reimbursement by PEEHIP.

PEEHIP MEDICARE PLUS *(Administered by Blue Cross)*

(Coverage for Medicare Eligible Retirees)

This plan is a supplement to hospital and medical benefits provided under Medicare Parts A and B and is available to Medicare eligible retirees. This coverage is similar in nature to C-Plus and other Medicare supplemental insurance plans. It provides hospital and non-hospital benefits as outlined below. This plan does not provide benefits for custodial care such as help in walking, eating, bathing and dressing. Members must have Medicare Part A and Part B, and Medicare must be your primary

payer for claims. Most Medicare eligible members and dependents should not enroll in the Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage.

PEEHIP Hospital Benefits *(Administered by Blue Cross)*

Benefit	Medicare Pays	PEEHIP Pays	YOU Pay
Inpatient Hospital Charges	All but the Part A deductible per admission. All but applicable coinsurance after 60 days.	All but $200 per admission and daily $25 copayment for days 2-5. Applicable coinsurance after 60 days.	A $200 deductible, copay of $25 per day for days 2-5 and any personal charges (such as private room, telephone, TV, etc.).

PEEHIP Non-Hospital Benefits

Benefit	Medicare Pays	PEEHIP Pays	YOU Pay
Outpatient Hospital Charges	80% of Medicare's approved amount after the Medicare Part B deductible.	20% of Medicare's approved amount after the member meets Medicare Part B deductible and the $30 copay for physician visit.	The Part B deductible, a copay up to $30 for physician visits, any charges not covered by Medicare or PEEHIP, and charges above the Medicare allowable amount when using unassigned providers.

Pharmacy Program *(Administered by MedImpact)*

- Participating Pharmacy: When using a Participating Pharmacy you pay the following:
  - $6 for any covered generic prescription drug
  - $40 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Web site at **www.rsa-al.gov**.)
  - $60 for any covered non-preferred brand drug
  - Approved maintenance drugs may be purchased up to a 90-day supply for one copayment of $12 for generic, $80 for preferred and $120 for non-preferred. The drug must be on the approved maintenance list and must be prescribed as a maintenance drug. First fill for a maintenance drug will be a 30-day supply.
- Participating pharmacies will file all claims for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP MedImpact prescription drug plan.
- Members and covered dependents need to use Bioscrip for all specialty medications.
- The PEEHIP prescription drug plan includes Step Therapy, prior authorization, and quantity level limitations for certain medications.
- Medicare Part B covered medications are excluded from coverage under the PEEHIP prescription drug benefit but will be covered under the Medicare Part B benefit.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama.
- Coverage outside Alabama: You will file the claim and be reimbursed at the Participating Pharmacy rate less the appropriate copay.

Out-of-State Coverage

- When you receive medical treatment outside Alabama, Medicare of that state is responsible for the payment of the claim. When you receive the Explanation of Medicare Benefits statement from that state, you must send Blue Cross a copy of the statement attached to a completed claim form in order for Blue Cross to consider the charges for payment. Always list your identification number on the claim form. Claim forms can be found on the PEEHIP Web site at **www.rsa-al.gov**.

Out-of-Country Coverage

- If you receive medical treatment outside the United States, Medicare may not make payment. In this situation, if the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross of Alabama.

Non-Participating Hospitals and Outpatient Facilities

- Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are Blue Cross and Blue Shield participating providers. With your health plan benefits, you have the freedom to choose your health care provider.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don't have to worry about extra out-of-pocket expenses.

Additional changes

In accordance with the Federal Health Care Reform Legislation, the following two changes have been made to the PEEHIP Hospital Medical Plan benefits:

- PEEHIP will not impose a copayment or deductible expense for immunizations or preventive care.
- PEEHIP will cover emergency services without the need for pre-authorization and will treat out-of-network ER benefits the same as in-network ER benefits.

Excluded Services

- Coverage is not provided for nursing home costs, charges in excess of Medicare allowed charges, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids, and experimental procedures.
- Medicare Part B covered medications are excluded from coverage under the PEEHIP prescription drug benefit but will be covered under the Medicare Part B benefit.

VIVA Health Plan Option

Description of Plan

The VIVA Health Plan is a Hospital Medical plan option available to active employees and non-Medicare-eligible retirees who do not have Medicare-eligible dependents; in addition, the members must live in one of the VIVA Health approved service areas shown on page 14 and must use providers in the VIVA Health network.

In addition to medical benefits, the VIVA Health plan option also includes dental benefits, vision benefits, and an extensive formulary. Except in some situations described below, all care must be received from Participating Physicians. With VIVA Health, PEEHIP members have access to 69 hospitals and over 5,200 physicians statewide. A brief explanation of benefits is below, and a comparison of the two plan options is on page 20.

The VIVA Health plan is not available to retired members who are Medicare eligible or to Medicare-eligible dependents.

Hospital Benefits

- Inpatient Hospitalization: Services are covered in full for 365 days without a dollar limit
- Copay: $200 for each admission. You are also responsible for the difference between private and semi-private accommodations and other non medical items such as TV, phone, etc.
- Prior Authorization: All inpatient admissions require authorization from VIVA Health prior to receiving services. Emergency admissions must be certified within 24 hours or as soon as reasonably possible for the admission to a covered service.
- Inpatient Rehabilitation: Coverage in a rehabilitation facility requires a referral from a Participating Physician and prior approval of the Medical Director. Coverage is limited to 60 days per calendar year and is covered 100% by VIVA Health
- **Outpatient Hospital Charges: $100 facility copay for outpatient surgery and $100 copay for emergency room services.** The emergency room copay is waived if admitted to hospital within 24 hours.

Major Medical Benefits

- There is no deductible on this plan
- There is no lifetime maximum on this plan.
- Covered Services: Physician service for medical and surgical care when you use a Participating Physician; diagnostic, x-ray, and laboratory procedures; ambulance services; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; physical therapy; allergy testing and physician services; semi-private room and other hospital care after basic hospital benefits expire.

Participating Physicians

- $0 copay per test after physician visit copay has been paid. Includes outpatient diagnostic, x-ray, and laboratory procedures
- $15 copay for Primary Care Physician visit
- $30 copay for Specialty Care. No referral required.
- **Preventive services are covered at 100%.**

Dental Benefits

- Deductible: $50 per person/$150 per family deductible applies to Basic & Major Services
- Maximum deductible: $500 Calendar year maximum
- Type I Diagnostic/Preventive Services: 100% coverage of maximum plan allowance (MPA). Services include routine oral exams, fluoride treatments (children under 19), cleanings, x-rays (limitations may apply), sealants, and space maintainers
- Type II Basic Services: 50% coverage of MPA. Services include fillings, simple extractions, palliative services, general anesthesia, and non-surgical periodontics
- Type III Major Services: 25% coverage of MPA and a 12 month waiting period. Services include major restorative (crowns, bridges, and dentures), denture repair, endodontics (root canals), surgical periodontics, and surgical oral surgery (includes surgical extractions).

Vision Exam Benefits

- Copay: One routine exam per year is covered in full after member pays a $30 copay. Other treatments are covered when medically necessary for the treatment of illness or injury.
- Does not require a Primary Care Physician (PCP) referral

Pharmacy Program

- Participating Pharmacy: When you choose a Participating Pharmacy you pay the following:
  - $12 copay for any covered generic prescription drug
  - ***$30 for any covered preferred brand drug**
  - ***$50 for any covered non-preferred brand drug**

  ** When an appropriate grade generic is available and a brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs.*
- Participating pharmacies will file all claims for you.

Non Participating Hospitals and Outpatient Facilities

- When choosing a Hospital, Outpatient Facility, or Provider you should first check to see if they are a participating provider/facility with VIVA Health. Your health plan benefits gives you the freedom to choose your healthcare provider among VIVA Health's contracted providers/facilities.
- To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don't have to worry about extra out-of-pocket expenses.
- Emergency medical care, including Hospital emergency room services and emergency ambulance services will be covered twenty four hours per day, seven days per week, if provided by an appropriate health professional whether in **OR** out of the Service Area if the following conditions exist:
  1. The Member has an emergency medical condition; and
  2. treatment is medically necessary; and
  3. treatment is sought immediately after the onset of symptoms (within twenty-four hours of occurrence) or referral to a Hospital emergency room is made by a participating physician.

Non-Participating Pharmacy

- There are no benefits if you use a non-participating pharmacy in Alabama

Excluded Services

- Coverage is not provided for cosmetic surgery, hearing aids, or experimental procedures. Other excluded services are listed in the Certificate of Coverage

Service Area

Coverage with VIVA Health is available in the following areas listed below. Also, you can go to the VIVA Web site at **www.vivahealth.com** to find providers in the VIVA Health network.

Autauga	Clarke	Etowah	Mobile	Tallapoosa
Baldwin	Conecuh	Fayette	Monroe	Tuscaloosa
Bibb	Coosa	Hale	Montgomery	Walker
Blount	Crenshaw	Jefferson	Morgan	Washington
Bullock	Cullman	Lawrence	Perry	Winston
Butler	Dale	Lowndes	Pike	
Calhoun	Dallas	Macon	St. Clair	
Cherokee	Dekalb	Madison	Shelby	
Chilton	Elmore	Marion	Talladega	

PEEHIP SUPPLEMENTAL COVERAGE PLAN

(Administered by Blue Cross)

The Supplemental Hospital Medical Plan will:

- Provide secondary coverage to the members and covered dependent(s) when primary coverage is provided by another employer.
- Only active and non-Medicare eligible retiree members are eligible to enroll in the Supplemental Plan.
- There is no premium cost for the plan when the member uses the state allocation for the Supplemental Plan.
- The Supplemental Plan covers most deductibles, copayments, and coinsurance not covered by the primary plan.
- Participants may elect individual or family coverage.
- PEEHIP Hospital Medical Plan exclusions and limitations continue to be imposed such as exclusions for dental coverage, cosmetic surgery, limitation on infertility treatment, etc.
- The Supplemental Plan does not cover or pick up any cost of services excluded by the primary plan because the plan is strictly a supplemental plan.
- The Supplemental Plan cannot be used as a supplement to Medicare, the PEEHIP Hospital Medical Plan, or the State or Local Governmental plans administered by the State Employees' Insurance Board (SEIB).
- The Supplemental Plan only supplements your primary insurance plan by covering the copay, deductible and/or coinsurance of your primary insurance plan or the preferred/participating allowance, whichever is less.
- To be eligible for reimbursement under the PEEHIP Supplemental Coverage Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
- For inpatient mental health and substance abuse services, there is a maximum allowance of 30 total days per member per plan year.
- For outpatient mental health and substance abuse services, there is a maximum allowance of 10 visits per member per plan year.
- The PEEHIP Supplemental Coverage Plan does not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of the maximums provided under the primary insurance plan, any services denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.
- PEEHIP members cannot be enrolled in the PEEHIP Hospital Medical Plan and the PEEHIP Supplemental Plan.
- Actively employed members who are enrolled in Tricare or Champus as their primary coverage cannot enroll in the PEEHIP Supplemental Plan.

ALL Kids Children's Health Insurance Program (CHIP)

The Federal Health Care Reform legislation now allows public education employees to participate in the ALL Kids CHIP program administered by the Alabama Department of Public Health (ADPH). Therefore, PEEHIP is no longer offering its CHIP program and current participants and new applicants need to apply for the ALL Kids CHIP program to receive medical coverage.

Eligibility for ALL Kids must be determined annually. Children may be eligible if they are:

- An Alabama resident
- Under age 19
- A U.S. Citizen or an eligible immigrant
- Not covered by other group health insurance*

** If a child has group health insurance that is voluntarily dropped, there is usually a three-month waiting period before that child can be eligible for ALL Kids.* **However, because dependents of public employees have been excluded from participating in CHIP since inception, this three-month waiting period will be waived for these children for a limited time.** *After this limited time period is over, the three-month waiting period for dropping coverage will apply.*

If you want to apply for ALL Kids for your child, submit your application to ADPH now! For more information about ALL Kids, go to www.adph.org or call 888.373.KIDS (5437).

How to apply:

- Complete an application online at www.adph.org or download a paper application from the ADPH Web site. You may also call 888.373.5437 to have an application mailed to you.
- ALL Kids will determine eligibility for your children and will let you know if:
  - your child is eligible and is being enrolled in ALL Kids,
  - your child is under income and your application is being forwarded to Medicaid, or
  - your child is over income and not otherwise eligible.

Monthly Gross Income Guidelines for Medicaid and ALL Kids

	Children Under 6 Years	
Family Size	**Medicaid**	**ALL Kids**
1	0-$1,207	$1,208-$2,723
2	0-$1,631	$1,632-$3,678
3	0-$2,054	$2,055-$4,633
4	0-$2,478	$2,479-$5,588
5	0-$2,901	$2,902-$6,543
	Children Ages 6-19 Years	
Family Size	**Medicaid**	**ALL Kids**
1	0-$908	$909-$2,723
2	0-$1,226	$1,227-$3,678
3	0-$1,545	$1,546-$4,633
4	0-$1,863	$1,864-$5,588
5	0-$2,181	$2,182-$6,543

Frequently Asked Questions about the ALL Kids Program

What is ALL Kids? ALL Kids is Alabama's Child Health Insurance Program (CHIP) and is administered by the Alabama Department of Public Health. ALL Kids provides low-cost, comprehensive health care coverage for children under age 19. Benefits include regular check-ups and immunizations, sick child doctor visits, prescriptions, vision and dental care, hospitalization, mental health and substance abuse services, and much more.

How much will ALL Kids cost? ALL Kids premiums are $50 or $100 per year per child, depending on the family income. ALL Kids copays range from $1-$20 depending on the covered benefit and family income.

How long can my child stay on ALL Kids? ALL Kids provides 12 months of eligibility, unless the child turns 19 or moves out

of state. Eligibility for coverage must be re-determined annually.

My child is 19 but is going to college, can you still cover him? No, ALL Kids cannot cover a child beyond his 19th birthday.

My spouse will still need dependent coverage, will my monthly premium be the same if I change my children to ALL Kids or can my children have both? A child cannot be covered by both. To continue covering your spouse, you will pay the same monthly premium for dependent coverage in PEEHIP, plus, there will be a small yearly premium for ALL Kids , per child. Copays will be lower in ALL Kids. You will have to make the decision whether to move your eligible children to ALL Kids or leave them on existing coverage.

Does ALL Kids offer dental coverage? Yes.

Does ALL Kids offer orthodontia coverage? ALL Kids covers orthodontia for limited conditions.

My child has a pre-existing condition, is there a waiting period? No, there is no waiting period for a pre-existing condition.

How long will the three month waiting period for voluntary dropping coverage be waived? The three-month waiting period will be waived beginning April 1, 2011, and will last through September 30, 2011, as long as there is no waiting list in ALL Kids.

OPTIONAL PLANS *(Administered by Southland National)*

(Cancer, Dental, Hospital Indemnity, and Vision)

There are four Optional plans offered through PEEHIP. A synopsis of these plans is provided below. More detailed information will be provided to those who enroll in the plan(s). Claims administration is provided through the Southland National Insurance Company. All Optional plans must be retained for the entire insurance year, i.e. until September 30. New employees employed during the Open Enrollment period cannot enroll in the Optional plans on their date of employment and cancel the plans October 1 of that same year.

If a member is enrolled in more than one of the Optional plans, the contracts must be all family or all single plans. Members enrolled in family Optional Plans cannot change to single Optional plans outside of the Open Enrollment period unless all dependent(s) become ineligible due to age, death or divorce. Listed below are merely summaries of benefits for the Optional plans. Members should refer to the PEEHIP Member Handbook for detailed information and limitations.

Cancer Plan

- This plan covers cancer disease only.
- Benefits are provided regardless of other insurance.
- Benefits are paid directly to the insured unless assigned.
- Coverage provides $250 per day for the first 90 consecutive days of hospital confinement, $500 per day thereafter.
- Actual surgical charges are paid up to the amounts in the surgical schedule.
- The lifetime maximum benefit for radiation and chemotherapy coverage is $10,000. This benefit covers actual charges for cobalt therapy, x-ray therapy, or chemotherapy injections (excluding diagnostic tests).
- Benefits are also provided for Hospice care, anesthesia, blood and plasma, nursing services, attending physician, prosthetic devices, and ambulance trips.

Dental Plan

- This plan covers diagnostic and preventative services, as well as basic and major dental services.
- Diagnostic and preventative services are not subject to a deductible and are covered at 100% (based on Alabama reasonable and customary charges). These services include: oral examinations, teeth cleaning, fluoride applications for insured children up to age 19, space maintainers, x-rays, and emergency office visits.
- Routine cleaning visits are limited to two times per plan year.
- Basic and major services are covered at 80% for individual coverage and 60% for family coverage with a $25 deductible for family coverage (based on the Usual Customary Rates (UCR) for Alabama). These services include: fillings, general anesthetics, oral surgery not covered under a Group Medical Program, periodontics, endodontics, dentures, bridgework, and crowns.
- The family coverage deductible for basic and major services is applied per person, per plan year with a maximum of three (3) per family.
- All dental services are subject to a maximum of $1,250 per year for individual coverage and $1,000 per person per year for

family coverage. Dental coverage does not cover pre-existing dentures or bridgework, nor does it provide orthodontia benefits.
- The dental coverage does not cover the replacement of natural teeth removed before a member's coverage is effective.
- This plan does not cover temporary partials, implants, or temporary crowns.
- The dental plan administered by Southland National also offers a money-saving network program known as DentaNet. Under the DentaNet program, members have the opportunity to use network dentists but still have the freedom to use any dentist.
- Dental benefits under this plan will always be paid secondary to other dental plans.

Hospital Indemnity Plan

- This plan provides a per-day benefit when the insured is confined to the hospital.
- The In-Hospital Benefit is $150 per day for individual coverage and $75 per day for family coverage.
- In-hospital benefits are limited to 365 days per covered accident or illness.
- Intensive care benefit is $300 per day for individual coverage; $150 per day for family coverage.
- Convalescent care benefit is $150 per day for individual coverage; $75 per day for family coverage.
- Convalescent care benefits are limited to a lifetime benefit of 90 days. This plan does not cover assisted living facilities.
- Cancer and maternity admissions are covered as any other illness.
- There is supplemental accident coverage for $1,000. The reimbursement for an accident(s) is limited to a maximum of $1,000 per contract year for each covered individual. There is no limit on the number of accident claims that can be filed per contract year.

Vision Care Plan

This plan provides coverage for:

- One examination in any 12-month period (actual charges up to $40)
- One new prescription or replacement prescription for lenses per plan year (up to $50 for single vision, $75 for bifocals, $100 for trifocals, and $125 for Lenticular)
- One new prescription or replacement of contacts per plan year (up to $100 for contact lenses)
- One new or replacement set of frames per plan year (up to $60)
- Either glasses or contacts, but not both in any plan year
- Disposable contact lenses
- Vision benefits under this plan will always be paid secondary to other vision plans.

Remember, this is only a summary of benefits. Members should refer to the appropriate benefit booklet for detailed information and limitations.

Coordination of Benefits

If an employee is enrolled in the dental and/or vision plans provided by PEEHIP and is also entitled to any other dental or vision coverage, the total amount that is payable under all plans will not be more than 100% of the covered expenses. In addition, PEEHIP will coordinate benefits with other dental and vision coverages. A member must correctly complete the Additional Group Health Insurance Coverage Information section of the Health Insurance and Optional Enrollment Application and update PEEHIP when changes are made.

Members and dependents are legally required to notify PEEHIP of other coverage. Also, employers must inform PEEHIP when other insurance coverage of any kind is provided to employees by their system. Claims incurred and filed on the PEEHIP dental and vision plans administered by Southland National are always paid secondary to other dental and vision plans.

Flexible Spending Accounts *(Administered by Blue Cross)*

We are all looking for ways to increase our spendable income and participating in PEEHIP's Flexible Spending Account program is one way that really works! You save money by not paying taxes on the contribution amount you elect. The PEEHIP Flexible Spending Accounts program is available to all active members of PEEHIP and is also a great way to offset the costs of your out-of-pocket copayments and deductibles. Retired members are not eligible to participate in any of the Flexible Spending Accounts. The PEEHIP Flexible Spending Accounts consist of the following three programs:

1. **Premium Conversion Plan** requires all active members to pay premiums for PEEHIP using pre-tax dollars. This plan is strictly a function of the payroll system in which the member no longer has to pay federal and state of Alabama income taxes on their health insurance premium.
2. **Dependent Care Flexible Spending Account** allows eligible active members the opportunity to pay dependent care expenses using pre-tax dollars.
3. **Health Care Flexible Spending Account** allows eligible employees to set aside tax-free money in an account to pay themselves back for eligible health care expenses incurred by them and their dependents.

The Open Enrollment deadline for the Flexible Spending Accounts is September 30, 2011, for an effective date of October 1, 2011. Members who are currently enrolled in a Flexible Spending Account through their employer are allowed to enroll in the PEEHIP spending accounts at the end of their employer's plan year. To continue the Flex Plan, members currently enrolled in the PEEHIP Flexible Spending Accounts must re-enroll every year. These programs do not automatically renew each year.

To enroll in the Flexible Spending Accounts, members can easily enroll in the Flexible Spending Accounts by using the Member Online Services system at **www.rsa-al.gov**. Members can also complete the Flexible Spending Account Enrollment Application located in the back of this packet and return the form to the PEEHIP office prior to October 1, 2011. More information is available at **www.bcbsal.org/peehip1/preferredBlue/index.cfm**.

Listed below are some of the eligible expenses that can be paid from your Flexible Benefits Account:

Health Care Flexible Spending Account

- Prescription drug co-pays
- Physician co-pays
- Vision care including Lasik and Prelex surgery
- Hearing care
- Deductibles
- Orthodontia
- Coinsurance
- OTC medications are eligible expenses only with a prescription.

Dependent Care Flexible Spending Account

- Licensed nursery school and day care facilities for children
- Child care in or outside your home
- Day care for an elderly or disabled dependent

To determine how much per year you want to contribute to your Flexible Spending Account(s), you should assess what your expenses were the year before and determine if these expenses will occur again and then add in any new expenses including the increase in copayments and deductibles. Your annual contributions must be whole dollars. The maximum annual amount for the Dependent Care Account is $5,000 if single or married filing a joint return or $2,500 if married filing a separate return; and $5,000 for the Health Care Account. The funds are deducted from your pay before taxes are withheld and deposited into your account.

If your medical and/or dental insurance is with any PEEHIP medical or optional plan, your out-of-pocket expenses for medical and/or dental services will automatically apply to your Flexible Spending Account. This saves you time and you get reimbursed quicker because you don't have to submit a claim form for reimbursement! If you have medical, dental or secondary coverage with another insurance plan, you will need to file a Request for Reimbursement form with appropriate documentation and provide documentation of what the other carrier paid.

The out-of-pocket money is reimbursed to you from your account. You may even elect to have it deposited directly into your checking or savings account. Amounts unused and unspent in the Health Care Flexible Spending Account as of September 30 can be used to pay for out-of-pocket medical expenses incurred during the 2 ½ month grace period ending December 15. Expenses for both the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year. If you do not use the money in your account from the previous plan year by the end of the grace period, you will lose it.

If you terminate employment or retire before the end of the plan year, your Flexible Spending Accounts will terminate the first day of the following month.

When a member retires or terminates employment before the end of the plan year, the member must use or incur the money in his or her Flex account by the Flex termination date. For example, if a member retires June 1, and the Flex account terminates September 1, the member must incur the covered expenses by September 1. Claims must be filed within 105 days from the end of the plan year.

COMPARISON OF BENEFITS

EFFECTIVE OCTOBER 1, 2011 – SEPTEMBER 30, 2012

(Changes are in bold)

This is a summary of your group benefits. Please be sure to read the entire "Summary Plan Booklet" for a complete list of benefits, limitations and exclusions.

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	**VIVA Health Plan*** (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Preventive Medical	$0 copayment then covered in full	**$0 copayment then covered in full**
Well Baby Care	$0 copayment per visit (6 visits 1st year; 1 visit/yr. thru age 6; one exam every 2 yrs ages 7 - 18)	**$0 copayment then covered in full**
Routine Immunizations	$0 copayment then covered in full	**$0 copayment then covered in full**
Office Care		
Physician's Care	$30 per visit	$15 per visit for primary care. $30 for specialty care. Referrals are no longer necessary.
Lab Procedure	$5 per test	Covered in full (after office visit copayment)
Inpatient Facility (including Maternity)**		
Physician's Care	Covered in full	$30 copayment (initial visit only) then covered in full
Inpatient	$200 hospital copayment and a $25 copayment for days 2-5	Covered in full after $200 hospital services copayment
Hospital Services	$200 copayment per admission and a $25 copayment for days 2-5	$200 copayment per admission
Outpatient Surgery	$150 copayment	**$100 copayment, then covered in full**
In-Hospital Care		
Surgeon	Covered in full	Covered in full
Physician Visits	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Emergency		
In Area/Out of Area Emergency Room Facility Charge	$150 per visit, accident within 72 hours covered 100% Members are also responsible for the physician copayment and lab fees.	$100 emergency room visit for facility, waived if admitted within 24 hours; Physician's charges covered at 100%.
Mental Health and Substance Abuse		
Inpatient	Copayments: Days 1-9 $0, days 10-14 $15, days 15-19 $20, days 20-24 $25, days 25-30 $30. Maximum of 30 days per member per fiscal year at approved facilities. Limit of one substance abuse admission per year and two admissions per lifetime.	Covered in full after $200 copayment.
Outpatient	$10 copayment for up to 20 outpatient visits at approved facilities.	Covered in full after $30 copayment.

**** Maternity benefits are not available to children of any age.**

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Prescription Drugs	(Administered by MedImpact)	
	Generic - $6 copayment Formulary (preferred brand name) drugs $40 copayment. Non-formulary (non-preferred brand name) drugs $60 copayment. Approved Maintenance drugs covered for 90-day supply for one copayment of $12 for generic, $80 for preferred, and $120 for non-preferred. The drug must be on the approved maintenance list and must be prescribed for 90 days. First fill for a new maintenance drug will be a 30-day supply. Certain medications have quantity level limits to comply with the FDA guidelines and to ensure drug safety for our members. Certain medications are subject to Step Therapy. Prior authorizations are required before covered members can receive certain medications. No benefits available when a non-participating pharmacy in the State of Alabama is used. Out-of-State non-participating pharmacies are paid at the participating pharmacy rate. Members pay difference in cost plus appropriate copayments. Pharmacists must dispense generic drug unless physician indicates in longhand writing on the prescription "Do Not Substitute", "Medically Necessary", or "Dispense as Written."	Generic - $12 copayment **Brand Name - *$30 preferred brand (formulary)** ***$50 non-preferred (non-formulary)** *When an appropriate grade generic is available and brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. 50% coverage for Mental Health drugs. 90% coverage for self-administered injectibles, bio-technical and biological drugs and maximum out-of-pocket is $1,000 per member per calendar year for these drugs. Participating pharmacies only. Mail Order pharmacy is available. Oral contraceptives are covered subject to the appropriate copayment.

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Other Services		
Out-of-State Coverage for Non-PPO Provider	Major Medical benefits apply - payable at 80% UCR after $300 yearly deductible	Only Emergency and Urgent Care Services and Prescription Benefits available
Out-of-State Coverage for PPO Provider	$30 copayment per visit. Members must use providers participating in the Blue Cross plan of that State.	Only Emergency and Urgent Care Services and Prescription Benefits available
Vision Examinations	Not Covered	Covered in full once each 12 months after a $30 copayment with participating provider.
Dental	Not Covered	The Dental Plan allows you to seek treatment from any licensed dentist. The plan reimburses a percentage of eligible expenses based on usual, customary and reasonable (UCR) fees. The VIVA dental benefit is administered by Delta Dental. Type I – Preventive & Diagnostic – 100% of UCR Type II – Basic Services – 50% of UCR Type III – Major Services** - 25% of UCR Deductible (applies to Basic & Major Services) - $50 per person/$150 per family Calendar Year Max - $500 **12-month Waiting Period applies to Major Services
Spinal Service & Chiropractic Services	Participating Chiropractor – Covered at 80% of the allowed amount with no deductible. After 12 visits in a calendar year, services are subject to precertification. Non-participating Chiropractor- Covered under major medical at 80% of allowed amount. Member will owe 20% coinsurance, major medical deductible of $300 and charges over allowed amount.	Limited to 20 visits per calendar year. $30 copayment per visit.
Infertility Services	Benefits for medically necessary infertility services are available for artificial insemination and related services. Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached. Benefits are not provided for Assisted Reproductive Technology (ART).	Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's lifetime). Treatment for infertility is not a Covered Service.

** VIVA Health Plan: No referral from a primary care physician (PCP) is required.*
Members must select a PCP and use participating physicians and specialists. Members must use participating hospitals.

Important Notice from PEEHIP About Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEEHIP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan or keep your PEEHIP drug coverage. If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PEEHIP has determined that the prescription drug coverage offered by the PEEHIP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing PEEHIP coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current PEEHIP Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to join a Medicare drug plan and drop your PEEHIP drug plan, your current PEEHIP drug coverage will terminate on the date that you enroll in a Medicare drug plan. Please be aware that you and your covered dependents will lose the PEEHIP drug coverage and you will not be able to get this coverage back until you drop the Medicare Part D coverage. You cannot have PEEHIP prescription drug coverage and Part D coverage at the same time.

If you enroll in a Medicare drug plan, you and your dependents will still be eligible for your current PEEHIP **health** benefits but will have no **prescription drug** coverage under PEEHIP.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PEEHIP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the PEEHIP office at 877.517.0020 for further information. **Note:** You will receive this notice each year and you may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800.633.4227). TTY users should call 877.486.2048.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Public Education Employees' Health Insurance Board has elected to exempt the **Public Education Employees' Health Insurance Program** from the following requirements:

- Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from these federal requirements will be in effect for the plan year beginning October 1, 2011. The election will be for every subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

For more information regarding this notice, please contact PEEHIP.

FORMS

Mail forms to: Public Education Employees' Health Insurance Plan
P.O. Box 302150
Montgomery, AL 36130-2150

A self-addressed envelope is included in this packet to return forms to PEEHIP. Do not send any forms to Blue Cross Blue Shield, VIVA, or Southland National. When completing these forms, make sure the name of the subscriber and dependents is the same as the name on their Social Security card. Forms may also be downloaded from our Web site at **www.rsa-al.gov**.

Health Insurance and Optional Enrollment Application – This form is to be used if you are: a **new** employee; an active or retired member who is **not** enrolled in any coverage; or an active or retired member who wants to **enroll** in one or more Optional Coverage Plans that you are not enrolled in, or are not enrolled in a Hospital Medical Plan and want to enroll. Any **changes** to existing coverages are to be made on the Health Insurance and Optional Status Change form.

Health Insurance and Optional Status Change – This form is to be used if you are an active or retired member currently enrolled in PEEHIP and you want to make changes to your existing coverage, and/or to certify or change your or your spouse's tobacco status. Examples: change from single to family coverage or vice-versa; cancel coverage; change your Hospital Medical Plan; add or cancel a dependent to or from family coverage; **enroll your adult child(ren) to your plan(s)**. **Important:** You must provide the Requested Effective Date or the form will be returned to you for completion.

Flexible Spending Account Enrollment Application – This form is to be used if you are an **active** member and you wish to enroll or re-enroll in the Health Care and/or Dependent Care Flexible Spending Accounts. **Important:** You must re-enroll in these programs **every year** as these programs will **not** automatically renew each year without a new enrollment application. The **Health Care Account** allows members to pay for non-covered health care expenses with pre-tax dollars. The **Dependent Care Account** allows members to pay for dependent care expenses with pre-tax dollars.

Flexible Spending Account Status Change – This form is to be used if you are an **active** member and you enrolled or re-enrolled in a Flexible Spending Account(s) during Open Enrollment and subsequently wish to make a **change** to the annual contribution amount of your Flexible Spending Account(s) **before** the end of Open Enrollment or during the year if you have a qualifying life event.

Federal Poverty Level Assistance (FPL) Application – This form is to be used by eligible active and retired members to apply for the FPL premium discount. **Members must re-enroll in this program every year.** This program will not automatically renew each year without a new application.

Important for New Employees
The Health Insurance and Optional Enrollment Application must be completed within 30 days of the member's employment date.

ONLINE FORMS

PEEHIP's Member Online Services offers a simple, convenient way to enroll for and make changes to your benefits electronically in one integrated process. The online system is fast, free, secure and accurate! Just click the Member Online Services link from the RSA web site at www.rsa-al.gov and enter your User ID and Password to access the online system. If you do not already have these, just click "Register Now" at the Log In screen and follow the on-screen prompts to create your own User ID and Password. **We encourage you to use the online system to make your Open Enrollment changes this year! During your online session you will receive your monthly out-of-pocket premium calculation, and at the end of your online session you will receive a Confirmation page confirming that your Open Enrollment elections were successfully saved and submitted to PEEHIP.**

PEEHIP Members Can Do the Following Online:

- During Open Enrollment (for an October 1 effective date):
  - Enroll, Change or Cancel your Hospital Medical Plan
  - Enroll, Change or Cancel your Optional Coverage Plans (cancer, dental, indemnity and vision)
  - Add, Update or Cancel your Other (non-PEEHIP) Group Insurance Coverage Information
  - Enroll or Re-enroll in Flexible Spending Accounts
  - Add or Update your Medicare Information
  - Add or Update Retiree Employer Information
  - Update your and your Spouse's Tobacco Usage Status
  - Add Dependent(s) to Coverage such as a newborn child or new spouse
  - Enroll your 19-26 year-old, adult child(ren) to any PEEHIP plan or the VIVA Health Plan.
  - Cancel Dependent(s) from Coverage
- **Outside of Open Enrollment** - Coverage for new dependents can be added through the online system for the following four **Qualifying Life Events (QLE) (for an effective date of the date of the event or the 1st of the month following the date of the event):**
  - Adoption of a Child
  - Birth of a Child
  - Legal Custody of a Child
  - Marriage of a Subscriber
- New Employees:
  - Enroll in coverage online (for an effective date of either the date of hire or the first day of the month following the date of hire)
- Year Round:
  - View your Current Coverages
  - View and/or Update your Contact Information (address, phone number, email and marital status)
  - View the History of your Confirmation pages
- **To Uncombine Allocations During Open Enrollment:**
  - **The easiest, most efficient and preferred way to uncombine allocations and enroll in single hospital medical plans is online through Member Online Services (MOS).** The subscriber of the hospital medical policy (for example, the receiver of the allocation) must first change **from** family hospital medical coverage **to** single hospital medical coverage. Once you receive a confirmation page generated by MOS confirming this election, the sender of the allocation should then log in to MOS and enroll in single hospital medical coverage and receive a confirmation page confirming this election. **Your confirmation page will also provide your premium calculation.** Each member must use his/her own PID number when using the MOS system.
- **To Remove An Ex-Spouse From Coverage Effective the 1st Day of the Month Following the Divorce:**
  - Click the "View/Change Contact Information" link once you have logged in to Member Online Services. Select the "Update my marital status" option, select "divorce" from the drop box, and then provide the date the divorce was final. This is the date the judge signed the Final Order of the Divorce Decree. Be sure to get a Confirmation page to ensure this change was saved and submitted to PEEHIP. This will remove the ex-spouse from your coverage.
  - If you do not have access to a computer, you may notify PEEHIP of your divorce by completing and mailing or faxing a paper Health Insurance Status Change form to PEEHIP.

PEEHIP Enroll
(06/11)
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HEALTH INSURANCE AND OPTIONAL ENROLLMENT APPLICATION

Check One:
☐ Active Member
☐ Retired

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to enroll in new coverages.
Any other changes are to be made on the Health Insurance and Optional Status Change Form.
In lieu of completing and mailing this form, you can enroll online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Sex
_____/_____/_____	_____-_____-_____	_____-_____-_____	☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Employer/School System	Email Address	Date of Employment
		_____/_____/_____

Have you or your spouse used tobacco products within the last 12 months?*
Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

***This information is required for enrollment.**

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions for dependents age 19 and over unless proof of previous coverage is received and approved by the PEEHIP office.

Basic Hospital/Medical
(*Select only one of the three plans*)

Note: *PEEHIP plans are administered by Blue Cross and Blue Shield of AL*

Coverage Type:
☐ PEEHIP Hospital/Medical
☐ PEEHIP Hosp/Med Supplemental**(*see Group Health on back*)
This plan is not a Medicare supplement & differs from Optional Plans.
☐ VIVA Health Plan (HMO)

☐ Single or ☐ Family

Requested Effective Date _____/_____/_____ ***(required)***

Primary Care Physician *(HMO only)*

Optional Coverage(s)
(*administered by Southland National*)

Note: *Optional plans must be all Single or all Family*

Coverage Type(s):
☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision

☐ Single or ☐ Family

Requested Effective Date _____/_____/_____ ***(required)***

Optional coverage(s) must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s). All cancellations must be indicated on the Health Insurance Status Change form.

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Enrollments cannot be processed without appropriate documentation for starred (*) items.* ***Birth certificates are required*** *for all children and marriage certificates for spouses.*

Name of Dependent *(First, MI, Last)*	Social Security Number	Date of Birth	Relationship to Subscriber	Sex	
			☐ Husband ☐ Wife	☐ M ☐ F	____/____/____ Marriage Date
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No

**Additional (Non-PEEHIP) Group Health Insurance Coverage Information

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder
Policy Effective Date _____/_____/_____	Type of Coverage ☐ Single ☐ Family
Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder
Policy Effective Date _____/_____/_____	Type of Coverage ☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.
If a member or dependent is under age 65, the PEEHIP office must receive a photostatic copy of the Medicare card before the premiums can be reduced.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Other Employer Information

The following fields need be completed only by PEEHIP members who retired after September 30, 2005.

Pursuant to Act 2004-649, if you retired after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No | If yes, please complete the employer information below.

Employer	Date of Employment	Last Day Employed
	_____/_____/_____	_____/_____/_____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date	Type of Coverage
	_____/_____/_____	☐ Single ☐ Family

PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review, and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the front of this form.

PEEHIP Change (06/11)
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HEALTH INSURANCE AND OPTIONAL STATUS CHANGE

Check One:
☐ Active Member
☐ Retired Member

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to make changes to your existing insurance coverages and to certify or change your tobacco status.
In lieu of completing and mailing this form, you can make your changes online using the Web site above.
Please print and complete the front and back of form.

PEEHIP Subscriber Information

Name must be entered as shown on Social Security card. ***All address changes must be made online or on the RSA Address Change Notification.***

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Date of Birth	Daytime Phone	Marital Status
____/____/____	____-____-____	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed (Legally)

Have you or your spouse used tobacco products within the last 12 months?* Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

****This information is required for enrollment.***

Please complete the following fields if you have changed your name or changed employers.

Previous Full Name *(First, MI, Last)* / Previous School System	New Full Name *(First, MI, Last)* / New School System	Date of Employment Transfer
		____/____/____

PEEHIP Coverage Information

For an effective date of coverage other than October 1, there is a 270 day waiting period for pre-existing conditions for dependents age 19 and over unless proof of previous coverage is received and approved by the PEEHIP office. The PEEHIP office will not automatically cancel any coverage(s).
All cancellations must be indicated on the Health Insurance Status Change form.

Coverage Type: (Only check boxes requiring a change)	**PEEHIP Hosp/Med**	**PEEHIP Supplemental ****	**VIVA HMO**	*(Optional plans must be all Single or all Family)* **Cancer**	**Dental**	**Indemnity**	**Vision**
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed below to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed below from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date ____/____/____ *(Date must be included or form will be returned)*
Note: You will be billed for prorata premiums or for premiums that are not deducted.

Reason for Status Change(s)

Changes cannot be processed without the appropriate documentation as explained in the member handbook for starred (*) items. ***Active members must have an IRS qualifying event to cancel their hospital medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed.***

☐ Adoption of a child* *(need adoption papers)*
☐ Birth of a child* *(need birth certificate)*
☐ Death of spouse/dependent* *(need death certificate)*
☐ Dependent loss of coverage* *(need proof of loss of coverage)*
☐ Divorce/Annulment* *(need divorce decree)*
☐ FMLA/LOA
☐ Legal custody of a child* *(need legal custody papers)*
☐ Marriage* *(need marriage certificate)*
☐ Marriage of dependent child
☐ Open Enrollment
☐ Termination of spouse/dependent employment*
☐ Commencement of spouse/dependent employment*
☐ Medicare/Medicaid entitlement* *(need copy of card)*

Date change occurred *(Required)* ____/____/____

Dependent Information *(only required for family coverage)*

Note: *Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Enrollments cannot be processed without appropriate documentation for starred (*) items.* ***Birth certificates are required*** *for all children and marriage certificates for spouses.*

Name of Dependent *(First, MI, Last)*	**Social Security Number**	**Date of Birth**	**Relationship to Subscriber**	**Sex**	
			☐ Husband ☐ Wife	☐ M ☐ F	____/____/____ Marriage Date
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No
			☐ Biological ☐ Adopted* ☐ Step* ☐ Other* _____	☐ M ☐ F	Handicapped ☐ Yes ☐ No

**Additional (Non-PEEHIP) Group Health Insurance Coverage Information

This section must be completed if the member elects the PEEHIP Supplemental Plan **or** if the member or dependent(s) have other group health, dental, or vision coverage currently in effect.

Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder
Policy Effective Date _____/_____/_____	Type of Coverage ☐ Single ☐ Family
Name of Insurance Company	Policy Number
Name of Policy Holder	Relationship to Policy Holder
Policy Effective Date _____/_____/_____	Type of Coverage ☐ Single ☐ Family

Medicare Information

This section must be completed if you or your dependents are eligible for Medicare.
If a member or dependent is under age 65, the PEEHIP office must receive a photostatic copy of the Medicare card before the premiums can be reduced.

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

Name	Medicare Card Number

Check the Medicare Part(s) for which you are eligible:

☐ Part A-Effective:_____/_____/_____ ☐ Part B-Effective:_____/_____/_____ ☐ Part D*-Effective:_____/_____/_____

**If you are enrolled in Medicare Part D, you are not eligible for the PEEHIP prescription drug plan coverage.*

Retiree Other Employer Information

The following fields need to be completed only by PEEHIP members who retired after September 30, 2005.

Pursuant to Act 2004-649, if you retired after September 30, 2005, and become employed by another employer and the other employer provides at least 50% of the cost of single health insurance coverage, you are required to use the other employer's health benefit plan for primary coverage. You may enroll in the PEEHIP Supplemental Plan or the PEEHIP Optional Plans.

Are you employed? ☐ Yes ☐ No | If yes, please complete the employer information below.

Employer	Date of Employment _____/_____/_____	Last Day Employed _____/_____/_____

Mailing Address	City	State	ZIP Code

Are you eligible for health insurance with your employer? ☐ Yes ☐ No

If yes, will your employer pay at least 50% of the cost of single health insurance coverage? ☐ Yes ☐ No

Name of Insurance Company	Policy Effective Date _____/_____/_____	Type of Coverage ☐ Single ☐ Family

PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review, and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Employee Signature _____ Date Signed _____/_____/_____

Mailing Address	City	State	ZIP Code

Please mail the completed form to the address located on the front of this form.

PEEHIP FSA
Enroll (03/11)
2H

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Email Address
_____/_____/_____	_____-_____-_____	_____-_____-_____	

Healthcare Flexible Spending Account Information

I wish to enroll in the Health Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- Do not include health insurance premiums in your annual election amount.
- The maximum annual amount cannot exceed $5,000 and the minimum annual amount is $120.
- Over-the-counter medications are not eligible for reimbursement beginning January 1, 2011.

Dependent Care Flexible Spending Account Information

I wish to enroll in the Dependent Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- **Do not enroll in the Dependent Care Flexible Spending Account for reimbursement of out-of-pocket medical costs for dependents. You must use the Healthcare Flexible Spending Account instead.**
- This plan is for:
  - licensed nursery school and daycare facilities
  - childcare in or outside your home
  - daycare for an elderly or disabled dependent
- The maximum annual amount cannot exceed:
  - $5,000 if single or married filing a joint return, or
  - $2,500 if married filing a separate return.
- The minimum annual amount is $120.
- Remember to factor in summer childcare costs.

PEEHIP Subscriber Certification

I understand that:

- I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Oct. 1 – Sep. 30) unless I have a qualifying change in status.
- During the Annual Open Enrollment Period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Oct. 1 – Sep. 30). I must enroll each year during the Open Enrollment period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year.
- Amounts unused and unspent in the Healthcare Flexible Spending Account as of September 30 can be used to pay for out-of-pocket medical expenses incurred during the 2 ½ month grace period ending December 15.
- Expenses for both the Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year.

I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Spending Account and all information furnished is true and complete.

Employee Signature _____ Date Signed ____/____/____

PEEHIP FSA Change
(03/11)
2l

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Email Address
_____/_____/_____	_____-_____-_____	_____-_____-_____	

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Reason for Status Change

I certify that I have incurred the following change in status:

- ☐ Marriage
- ☐ Marriage of dependent
- ☐ Birth of a child
- ☐ Adoption of a child
- ☐ Legal custody of a child
- ☐ Divorce/annulment
- ☐ Death of spouse/dependent
- ☐ Dependent loss of coverage
- ☐ Significant change in medical benefits or premiums
- ☐ Termination of spouse/dependent employment
- ☐ Commencement of spouse/dependent employment
- ☐ Taking leave under the Family and Medical Leave Act
- ☐ Medicare/Medicaid entitlement
- ☐ Unpaid Leave of Absence
- ☐ Short plan year

Date qualifying event occurred ***(Required)*** _____/_____/_____

Note: *PEEHIP must be notified within 45 days of the occurrence of the qualifying event.*

Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000 and the minimum annual amount is $120.

☐ Stop Payroll Deductions

Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $5,000 if single or married filing a joint return, $2,500 if married filing separate returns. The minimum annual amount is $120.

☐ Stop Payroll Deductions

PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature _____ Date Signed _____/_____/_____

PEEHIP FPL
(06/11)
2G

FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION (FPL)

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to apply for the Federal Poverty Level Premium Assistance.

PEEHIP Subscriber Information - *Required*

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Home Phone	Work Phone	Date Received *(For internal use only)*
_____-_____-_____	_____-_____-_____	_____/_____/_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Instructions

1. A **signed** copy of your prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's must be attached. If you were married and did not file a joint return, you must also file a copy of your spouse's prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's in order for this application to be processed.
2. You must reapply for this assistance every year during Open Enrollment.
3. Any Federal Poverty Level assistance application received and/or postmarked after the close of Open Enrollment (September 1) will be effective for the first day of the second month after the receipt and approval of the application.

PEEHIP Subscriber Certification - *Required*

I declare that the above information and the accompanying tax returns and supporting 1099's and W-2's are true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any statements or accompanying tax returns and supporting 1099's and W-2's are found to be incorrect, incomplete, false, or misleading, I will be required to repay all discounts plus interest. This certification authorizes the Alabama Department of Revenue (or corresponding agency of the state of member's residency) to release to PEEHIP all of the member's and his/her spouse's tax returns in the agency's records for the current and prior tax year.

Employee Signature _____ Date Signed _____/_____/_____

Spouse Signature _____ Date Signed _____/_____/_____

Please mail the completed form to the address located on the top of this form.
See reverse for FPL levels.

PEEHIP provides premium assistance to PEEHIP members with a combined family income of less than or equal to 300% of the Federal Poverty Level (FPL) as defined by Federal Law. To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of Income Level will be effective for the plan year only, and re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the hospital medical premium or HMO premium and only applies to active and retired members. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA or surviving spouse contract.

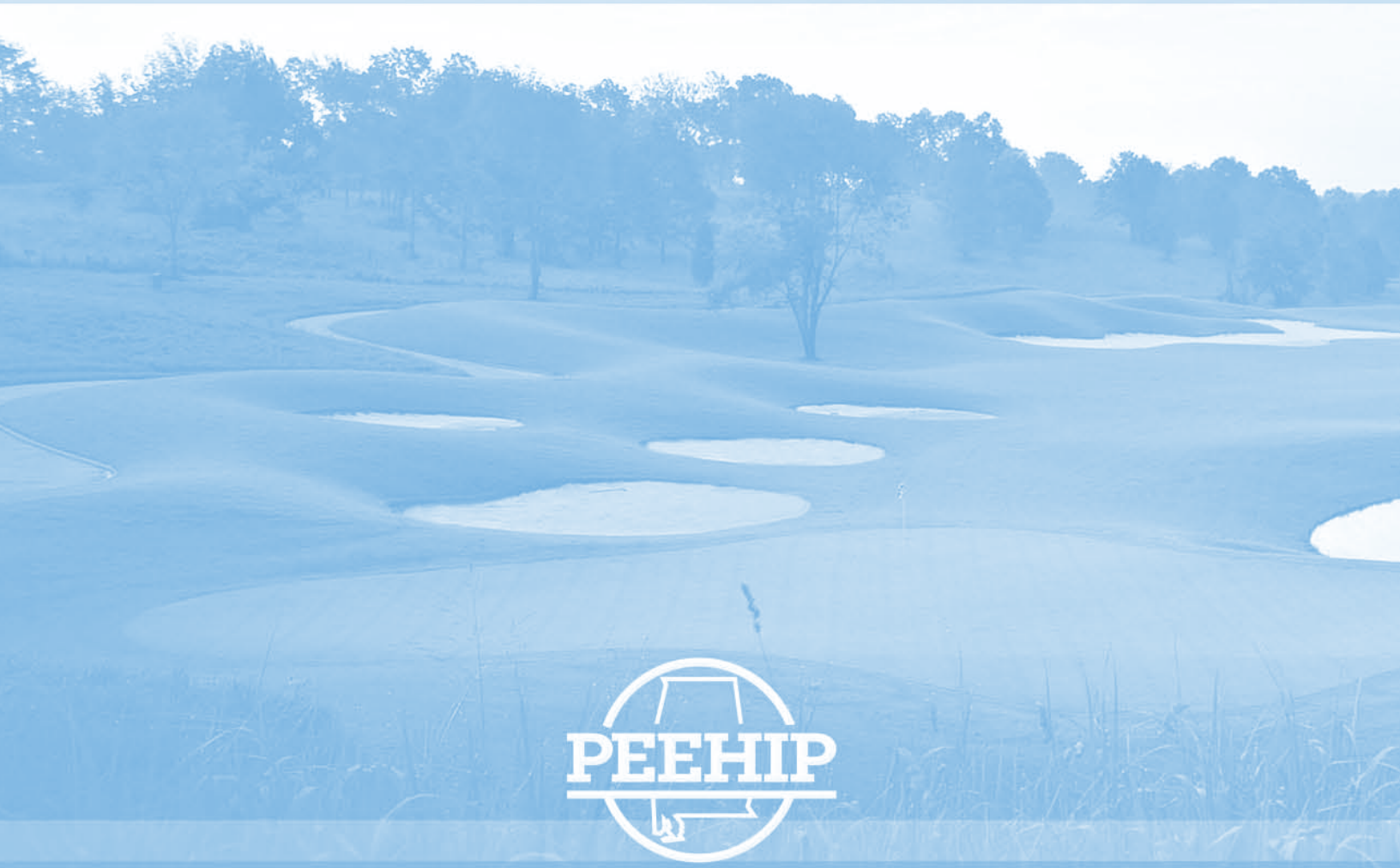
Federal Poverty Level Premium Discount:

Over 300% of the FPL	member pays 100% of the member contribution	
equal to or less than 300% but more than 250% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 250% but more than 200% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 200% but more than 150% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 150% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2011 Federal Poverty Levels (FPL)

Family Size	100% of FPL	150% of FPL	200% of FPL	250% of FPL	300% of FPL
1	$10,890	$16,335	$21,780	$27,225	$32,670
2	$14,710	$22,065	$29,420	$36,775	$44,130
3	$18,530	$27,795	$37,060	$46,325	$55,590
4	$22,350	$33,525	$44,700	$55,875	$67,050
5	$26,170	$39,255	$52,340	$65,425	$78,510
6	$29,990	$44,985	$59,980	$74,975	$89,970
7	$33,810	$50,715	$67,620	$84,525	$101,430
8	$37,630	$56,445	$75,260	$94,075	$112,890

Deadline August 31, 2011
Effective October 1, 2011



PEEHIP

PUBLIC EDUCATION EMPLOYEES'
HEALTH INSURANCE PLAN
P. O. Box 302150
Montgomery, Alabama 36130-2150
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